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MT LEGISLATIVE HISTORY

Chapter 665 1991

Bill H _____ S 394 Original bill & hist. ___C

H. Committee on Business & Economic Development S. Committee on Business & Industry

Hearing Date(s)		Hearing Date(s)	
Mar 15	✓C	Feb 20	✓C
Mar 20	✓C	Feb 23	✓C
_____	___C	_____	___C
_____	___C	_____	___C
Date Out Mar 21	✓C	Feb 22	✓C

Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

2/14	INTRODUCED		
2/15	FIRST READING		
2/15	REFERRED TO JUDICIARY		
2/21	HEARING		
2/22	TABLED IN COMMITTEE		
2/22	TAKEN FROM TABLE		
2/23	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/25	2ND READING PASSED	49	0
2/26	3RD READING PASSED	48	1
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO JUDICIARY		
3/18	HEARING		
3/18	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/21	2ND READING CONCURRED	73	21
3/23	3RD READING CONCURRED	72	27
	RETURNED TO SENATE WITH AMENDMENTS		
3/28	2ND READING AMENDMENTS CONCURRED	49	0
4/01	3RD READING AMENDMENTS CONCURRED	48	0
4/03	SIGNED BY PRESIDENT		
4/03	SIGNED BY SPEAKER		
4/04	TRANSMITTED TO GOVERNOR		
4/08	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 384	EFFECTIVE DATE: 10/01/91	

SB 393 INTRODUCED BY KENNEDY
STANDARDS FOR OUT-OF-STATE PHARMACIES AND FOR PATIENT COUNSELING

2/14	INTRODUCED		
2/15	FIRST READING		
2/15	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
2/20	HEARING		
2/23	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/25	2ND READING PASSED	49	0
2/26	3RD READING PASSED	49	0
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO HUMAN SERVICES & AGING		
3/19	HEARING		
3/23	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/06	2ND READING CONCURRED AS AMENDED	89	2
4/06	ON MOTION RULES SUSPENDED TO PLACE ON 3RD READING THIS DAY		
4/06	3RD READING CONCURRED	96	1
	RETURNED TO SENATE WITH AMENDMENTS		
4/17	2ND READING AMENDMENTS CONCURRED	49	0
4/18	3RD READING AMENDMENTS CONCURRED	49	0
4/22	SIGNED BY PRESIDENT		
4/23	SIGNED BY SPEAKER		
4/23	TRANSMITTED TO GOVERNOR		
4/26	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 664	EFFECTIVE DATE: 10/01/91	

SB 394 INTRODUCED BY SVRCEK, ET AL.
REGULATE CONDUCT OF UTILIZATION REVIEWS BY HEALTH INSURERS

2/14	INTRODUCED
2/15	FIRST READING
2/15	REFERRED TO BUSINESS & INDUSTRY
2/15	FISCAL NOTE REQUESTED
2/20	HEARING
2/21	FISCAL NOTE RECEIVED

2/23	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/25	2ND READING PASSED AS AMENDED	47	2
2/26	3RD READING PASSED	43	6
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO BUSINESS & ECONOMIC DEVELOPMENT		
3/08	REVISED FISCAL NOTE REQUESTED		
3/09	FISCAL NOTE PRINTED		
3/13	REVISED FISCAL NOTE RECEIVED		
3/14	REVISED FISCAL NOTE PRINTED		
3/15	HEARING		
3/21	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/06	2ND READING CONCURRED	83	7
4/06	ON MOTION RULES SUSPENDED TO PLACE ON 3RD READING THIS DAY		
4/06	3RD READING CONCURRED	95	2
	RETURNED TO SENATE WITH AMENDMENTS		
4/17	2ND READING AMENDMENTS CONCURRED	49	0
4/18	3RD READING AMENDMENTS CONCURRED	49	0
4/23	SIGNED BY PRESIDENT		
4/24	SIGNED BY SPEAKER		
4/24	TRANSMITTED TO GOVERNOR		
4/26	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 665	EFFECTIVE DATE: 10/01/91	

SB 395 INTRODUCED BY PINSONEAULT, ET AL.
REVISE LAWS RELATED TO TRANSFER OF TERRITORY OF SCHOOL DISTRICTS

2/15	INTRODUCED		
2/15	FIRST READING		
2/15	REFERRED TO EDUCATION & CULTURAL RESOURCES		
2/20	HEARING		
2/21	COMMITTEE REPORT—BILL PASSED		
2/23	2ND READING PASSED	49	0
2/25	3RD READING PASSED	49	0
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO EDUCATION & CULTURAL RESOURCES		
3/21	HEARING		
4/02	COMMITTEE REPORT—BILL CONCURRED		
4/06	2ND READING CONCURRED	90	0
4/06	ON MOTION RULES SUSPENDED TO PLACE ON 3RD READING THIS DAY		
4/06	3RD READING CONCURRED	96	1
	RETURNED TO SENATE		
4/13	SIGNED BY PRESIDENT		
4/15	SIGNED BY SPEAKER		
4/15	TRANSMITTED TO GOVERNOR		
4/20	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 517	EFFECTIVE DATE: 7/01/91	

SB 396 INTRODUCED BY ECK
IMPOSE A TAX ON THE RENTAL OF VIDEO TAPES

2/15	INTRODUCED
2/15	FIRST READING
2/15	REFERRED TO TAXATION
2/15	FISCAL NOTE REQUESTED
2/19	FISCAL NOTE PRINTED
2/21	FISCAL NOTE RECEIVED
3/15	HEARING
3/22	TABLED IN COMMITTEE

SB 330 do passed unanimously.

HEARING ON SENATE BILL 394

Presentation and Opening Statement by Sponsor:

Senator Paul Svrcek, sponsor of the bill, stated that this bill deals with utilization review. Utilization review is a system by which primarily a third party provider reviews the circumstances under which they will provide payment for a various medical services. Utilization review is a good process, it helps keep costs down. Many other states have codes on the books that regulate utilization review because of some problems. Those problems stem from situations whereby a person feels that they are covered for a certain medical service, and they go and have the service, then are surprised when the third party provider comes and says that the service is not covered and they have been rejected. There is a serious problem that has developed in Montana regarding drug and alcohol rehabilitation as well as mental healthcare. Senate bill 394 in no way prohibit utilization review, but it does set down certain criteria which would govern the use of utilization review.

Proponents' Testimony:

Mona Sumner, clinical director of the Rimrock Foundation in Billings, MT, spoke in favor of the bill (See Exhibit 6 and 6A).

Mary Huntington-Lehner, a licensed social worker in Montana as well as a chemical dependency counselor, stated that the people she works with have increasing lost power and control in themselves and their behaviors as a result of their having lost control over substances, such as alcohol, etc. They are asking for the benefits that they have paid for to be delivered for this type of treatment. The insurance companies are loosing control over the amount of money that is being spent on the healthcare. It is the individual and their families that suffer as a result.

Mike Rupert, president of the chemical dependency program of Montana and executive director of the Boyd Andrew chemical dependency care center in Helena, stated that the trends of utilization review are benefitting out patient programs.

John Shontz, representing the Montana health association, stated that he appears today on behalf of the consumers and not the providers. This legislation does not abolish utilization review, it regulates it. He suggested an amendment for page four of the bill, line nineteen so it reads "that has been approved by the commissioner".

Mona Jamieson, representing the rocky mountain treatment center, stated that this is a bill is disclosure. It is not a bill that eliminates or outlaws utilization review. This bill is about fairness and disclosure. Let's have a fair playing field.

Dan Edwards, international representative for the quaill chemical and atomic workers international union, stated that

since November blue cross blue shield has decided that no patient was worthy of admission to rimrock.

Jim _____, president of the Montana hospital association, stated that this issue is a problem for all hospitals not just for hospitals that have psychiatric care units. (See Exhibit 7 and 7A).

Mary McCue, representing the Montana mental health counselor's association, stated that they have had some problems with the utilization process.

Pat Melby, representing the rimrock foundation, stated that many of the things in this bill have been recommended by in this bill have been recommended by one of the largest law firms in the United States who represent utilization review agencies and insurance companies on utilization related issues. That law firm has recommended to third party payers, insurance companies, and utilization agencies, that they do many of the things that this bill would require them to do.

Opponents' Testimony:

Steve Turquewitz, executive vice president of the Montana auto dealers association, stated that their claims are the sole driving force for their premiums. The claims are tracked on a monthly basis. In the last two years they have had to raise their rates 104%. They have lost three hundred people from their insurance program in the past year. The greatest provider of insurance in the state isn't the Blues, but it is those people that aren't covered by insurance at all.

Bonnie Tippy, representing the Montana chiropractic association, stated that page 3 of the bill under section 2 sub A. They have taken chiropractors into this bill the reason that they don't like that is because the bill also requires that the only people who can do these utilization reviews are medical doctors. That is a real problem for chiropractors in the state of Montana. In practice right now chiropractors do utilization reviews for chiropractic patients. This bill would mandate that the primary utilization reviewer must be a medical doctor. This is a bad policy for the state of Montana, bad policy for the patients of chiropractors, and for the other providers included in this bill.

Joyce Brown, with the state employed health plan, spoke in opposition of the bill (See Exhibit 9).

Dan _____, representing the Martin _____ company, an international consulting and actuary firm, stated that the whole interest of the bill comes from a change that was made in a blue cross blue shield policy for managed care in relation to chemical dependency or substance abuse. The bill is so far reaching it will cover every provider in the state, there are very few cases that are turned down under utilization and managed care.

Dave Hartman, executive director with the Montana education association, stated that the adoption of this bill will

effectively destroy meaningful utilization review procedures and practices in Montana. To do so will only contribute to inflationary rates.

Nancy Ellery, administrator of the medicade services division at SRS, stated that medicade is concerned because this year their budget will exceed over two hundred million dollars, and utilization review is a very important part in containing those healthcare costs and more importantly making sure that people who have medicare get care in the appropriate settings. They are not opposed to the bill entirely, some of their concerns is the requirement that the physician approve all those medical necessity decisions.

Tom Hopgood, speaking today on behalf of the health insurance association of America, he stated that he does not represent blue cross blue shield or manage care Montana. Utilization review, as stated by blue cross blue shield, saves the consumer in Montana approximately eight million dollars a year. If market shares are roughly equal, the commercial insurers also use utilization review and would save another eight million dollars for the consumers. We are talking about a bill with a sixteen million dollar price tag. The rule making authority is given to the insurance commissioner. This is a bill regulating healthcare services.

David _____, with the university system and also the administrator of the university system health plan, stated his name in opposition of the bill.

Howard Bailey, program administrator of the Montana unified school trust, stated his name in opposition of the bill.

Steve Brown, representing blue cross blue shield, submitted a manage care package (See Exhibit 8).

Larry Akey, representing Montana association of life underwriters, stated his name in opposition to the bill.

Questions From Committee Members:

Senator Thayer asked Steve Brown, Blue Cross Blue Shield, to address the twenty five cases of where Rimrock said treatment was denied.

Steve Brown replied there were not twenty five cases and that individual circumstances needed to be reviewed. At least one claim was for gambling-a non covered condition. Another patient was diagnosed by her attending physician as needing hospitalization. Is a chemical dependency center the appropriate place for psychiatric hospitalization.

Senator Thayer stated that Mr. Hopgood indicated in testimony that he's pointing out some problems with the bill.

Tom Hopgood stated that in section 7 it states that a person that is conducting a utilization review needs to be in the practice of medicine under title thirty seven. Section 9 provides that an administrator of a self insured plan which is exempt from regulation is subject to the act. This will cost the state some money through the self insured plan and through the

university system.

David Barnhill stated that the bill has merit, but it also causes some problems in the insurance department. This bill is to head of unfair denial of claims.

Senator Williams asked why there was a lack of need for a fiscal note.

Pat Melby stated that the cost to the insurance commissioner would be very nominal.

Senator Gage asked about page six, line 17, asked if they do that currently.

Steve Brown, representing blue cross, the person that is reviewing healthcare services contact the attending physician. Blue cross blue shield's manage care plan states that in order for there to be a denial, they must attempt to contact the patients physician, and the physician for rimrock has said he does not want anyone to call him. Mr. Brown also refuted the allegation that twenty five patients of rimrock had services denied.

Closing by Sponsor:

Senator Paul Svrcek closed by saying that with the exception of the people that have talked about the problems with the physicians reviewing the healthcare provided by a different kind of healthcare provider. He is willing to work with this amendment that will address that concern. None of the opponents have addressed the specifics of this bill. This bill doesn't outlaw utilization review, all it does is say you want utilization review, we agree it's needed. Please tell us what are your rules for utilization review. Please tell us so that we can tell the people that we are providing the healthcare insurance to so that they can conduct their lives, and they can conduct their seeking out of medical services.

ADJOURNMENT

Adjournment At: 12:00 a.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JDL/dia

ROLL CALL

BUSINESS & INDUSTRY COMMITTEE

DATE 2/20/91

____ LEGISLATIVE SESSION ____

NAME	PRESENT	ABSENT	EXCUSED
BRUSKI	X		
FRANKLIN	X		
GAGE	X		
HAGER	X		
NOBLE	X		
THAYER	X		
WILLIAMS	X		
KENNEDY	X		
LYNCH	X		

Each day attach to minutes.

DATE 2/20/91

COMMITTEE ON BUSINESS & INDUSTRY

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Sam Yturriaga	Montana Fair Housing	363	✓	
Jeffrey O. Brazier	HBPA	330T 363	✓	
Dan Kemmis	Kalispell Chamber Fair Housing	SB 330 SB 363	✓	
Doug CHANCE	MT. TRUCKS	SB 363	✓	
George LEHNER	Kom MT JT COMM	SB 394	✓	
Mary Lynch for Rehbein	Rocky Mountain Dental Assn	SB 394	✓	
Mona Jamieson	Rimrock Fnd	SB 394		
Robert W. Olsen	MT Hospital Assoc.	SB 394	✓	
Nancy Ellery	SRS Medicaid			✓
[illegible]	Rimrock Fdn.	S.B. 394	✓	
Jane Ebzery	St Vincent Hospital	SB 394	✓	
Tom Hopgood	Health Ins Assoc Amer	SB 394		✓
Pat Melby	Rimrock Foundation	SB 394	✓	
John Shontz	Mental Health Assn	SB 394	Y	
Andy Poole	DEPT OF COMMERCE	SB 330	Y	
Steve Brown	Blue Cross - Blue Shield	SB 394		✓
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	SB 394		✓
LARRY AKEY	CLAIMING INDUSTRY ASSOCIATION	SB 363 w/ AMEND		
Bonnie Tippy	MT Chiropractic Assn	SB 394		X
DON EDWARDS	OCHAW	SB 394	X	
Dave Barnhill	Insurance dept.	SB 394	+	+
Ellwood Hartman	MEA	SB 394		X
JUDITH A CARLSON	MT CH - NASW	SB 394	X	
Mary McCue	MMHCA	SB 394	X	

(Please leave prepared statement with Secretary)

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of Feb, 1991.

Name: Mona L Summa

Address: 715 Beverly Hill Blvd
Billings, Mt

Telephone Number: 252-8147

Representing whom?
Kennedy Foundation

Appearing on which proposal?
SB 394

Do you: Support? X Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of February, 1991.

Name: Mary MaCue

Address: 1215 11th Ave
Helena MT 59624

Telephone Number: 442-4448

Representing whom?
Mt. Mental Health Counselors Ass'n.

Appearing on which proposal?
SB 394

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of February, 1991.

Name: Nancy Ellery

Address: PO Box 4210

Telephone Number: 4444540

Representing whom?

SRS - Medicaid

Appearing on which proposal?

SB 394

Do you: Support?____ Amend?__/__ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of February, 1991.

Name: J. Shontz

Address: 311 N Last Chance Gulch
Helena MT 59601

Telephone Number: 443-7018

Representing whom?

Mental Health Assoc. of Montana

Appearing on which proposal?

SB 394

Do you: Support? X Amend?____ Oppose?____

Comments:

bill should require that the commission of insurance must approve all utilization review plans before they (the plans) can be implimented.

I've offer an amendment:

PAGE 4 LINE 19

FOLLOWING: "plan"

ADD: "that has been approved by the commissioner of ins..."

Thank you.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20th day of February, 1991.

Name: DAVID HARTMAN

Address: 1232 E. 6TH AVE
HELENA, MT

Telephone Number: 442-4250

Representing whom?

MEA

Appearing on which proposal?

SB 394

Do you: Support?____ Amend?____ Oppose? X

Comments:

This bill will destroy effective utilization review programs and put limitations for medical services. Unions and employers have established effective utilization review programs to control costs. SB 394 will devastate these programs.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20th day of February, 1991.

Name: Howard A Bailey

Address: 1 S Mt. Ave, Helena

Telephone Number: 442-0275

Representing whom?

Mt. Unified School Trust

Appearing on which proposal?

SB 394

Do you: Support?____ Amend?____ Oppose? X

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of FEBRUARY, 1991.

Name: Robert W. Olsen

Address: 1720 N. 29th Ave

Telephone Number: 442-1911

Representing whom?

MT Hospital Assoc.

Appearing on which proposal?

SB 394

Do you: Support? ✓ Amend?____ Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 6
DATE 2/20/91
BILL NO. SB 394

RIMROCK FOUNDATION®

Leading Quality Addiction Treatment in the Northern Rockies

TESTIMONY IN SUPPORT OF HB 394

BY MONA L. SUMNER

In over twenty two years as an addiction treatment professional, I never expected to be here before you today testifying on a bill like this. Because for most of these 22 years, here in Montana, I have been part of the struggle to bring alcoholism and drug dependence out of the closet, and reducing the stigma so people would freely seek the help they so badly need. When this happens, we all benefit. Ten percent of our people have this addiction, here in Montana and also, nation-wide. Insurance claims for chemical dependency constitute 4/100 of 1 percent of claims. This tells me that while public education has helped, there are still large numbers of individuals needing care who are not obtaining it. There are no doubt many reasons for this, among them the tremendous denial of the problem that characterizes the illness. When, however, the patient does seek help, often under threat of losing family, job and other important aspects of his life, it is crucial that help be accessible.

We have a very serious situation which has developed in Montana and which is making treatment for addiction inaccessible to our people. Some examples of how this is happening may serve to help you understand why you need to support this bill.

I bring with me today, the stories of twenty five patients who have sought help for their addiction problem from my center since November, each of whom had Blue Cross coverage. None of these patients knew at the time they presented at my facility that their worst problem would not be in overcoming their addiction problem--but would instead be obtaining reimbursed care from their insurance company.

As with all addicts, each of these had reached their lowest and most desperate point at the time they sought help, or so they thought until each learned their insurance company would deny their treatment benefits.

Rimrock Foundation has, for the past four years, used the National Patient Placement Criteria published by the American Society of Addiction Medicine--criteria which establish whether a patient needs inpatient or outpatient level services with the goal of assuring care at the most cost-effective level. We have worked with over thirty utilization review firms representing over sixty insurance companies during this period and experienced only two instances of denials against our criteria. November, however, changed all that.

Managed Care of Montana, the utilization review entity owned by Blue Cross/Blue Shield, hired two Minnesota based physicians--not addictionologists, to develop criteria for medical necessity. Blue Cross was asked by Montana treatment providers to adopt the National Placement Criteria. They did not. Despite meetings with them, in which their criteria were criticized as economic barriers, they held firm. Admissions and stays must be curtailed, costs are out of control! Yet, chemical dependency and mental health claims constitute 7% of their payouts.

Beginning in November, every single Blue Cross patient at our facility as been denied either admission or continued stay. When our physician points that out, in his opinion, the patient exceeds the national criteria and, even meets Blue Cross's own criteria which are ill-founded, the patient is still denied. There can be no question about what's going on here...surely not every single patient warrants denial.

Imagine if you were the father of a 19 year old who has been diagnosed seriously depressed, with previous suicide attempts, using alcohol, pot, and cocaine daily, unable to stop, bulimic for two years, and learned that your daughter's condition was not severe enough to warrant residential treatment--that she should be an outpatient. Imagine how that father felt when outpatient treatment was not even available in his community!

There are twenty four more of these same stories--one individual who, while intoxicated, attempted to kill himself and destroyed his lower jaw. His physician told him he wouldn't be that fortunate again if he did not have inpatient treatment for his depression and alcoholism and sent him to us. His story was the same, not serious enough to warrant more than three days inpatient. It takes ten days for psychotropic medications to help these patients. He was denied anyway...and so

it goes through all remaining twenty three stories. As I stand here today, more denials are occurring at my facility and more care is being compromised. Each of these patients is actively seeking recourse--recourse they should have through the insurance commissioner's office but do not have without this legislation. These people should not have to go to court to get what they signed up for and paid premiums for--medically necessary care for their illness.

Some denials are even more tragic. Upon learning they will be denied, some don't even pursue further services, leaving themselves, their families and you and I at risk from their illness.

No doubt opponents will argue that much of the care being delivered is not "medically necessary". I can assure you that three Montana physicians and two Montana psychiatrists who saw all twenty five of these patients felt their admission and continued stay was medically necessary.

On behalf of these twenty-five and those who will be denied tomorrow and the day after, I implore you to support this legislation. To allow fifteen years of progress treating this nation's drug problems to be managed by utilization reviewers who care only that there commission goes up when care goes down, is an unspeakable abuse.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 6A
DATE 2/20/91
BILL NO. SB 394

George F. Sheckleton, M.D.

1231 North 29th Street Billings, Montana 59101 (406) 248-3175

February 20, 1991

TESTIMONY IN SUPPORT OF SB 394
George F. Sheckleton, M.D.

As a physician, I am closely involved with Managed Care and I employ five other physicians who must also respond to these utilization review firms. As a public health officer in Yellowstone County, as well as a private physician, I share your concerns about healthcare cost containment and have worked willingly with these companies to assure that patients receive their medical services in the least restrictive and most cost-effective setting possible.

Recently, however, I have become alarmed over the practices of some of these companies. One, in particular, Managed Care of Montana, has, since November, denied every patient seeking services at Rimrock Foundation where I am the Medical Director. It seems none of these patients meet their definition of medical necessity. I am a certified addictionologist and member of American Society of Addiction Medicine and I apply criteria for medical necessity approved by this organization, which is why I urge your support of this bill. It will require these firms to use nationally recognized criteria for medical necessity, thus ensuring that patients will be evaluated against professional clinical standards, not economic interests.

Of particular concern to me is that I am usually justifying my opinion to a physician reviewer who is from another state and who has never seen the patient, but appears to have a vested interest in refuting my opinion. I am too often told "Well, Doctor, if I were in your situation with the patient, I would probably feel the same way and make the same recomendations, but since I am not, I am going to deny the service."

The clinical needs of these patients are clearly not the primary basis for determination of medical necessity by these firms and I believe it is crucial to provide some regulation and a means to stop such substandard practices.

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVE.
P.O. BOX 5119
HELENA, MT
59604
(406) 442-1911
FAX 443-3894

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 7
DATE 2/20/90
BILL NO. SB394

Testimony of
Robert W. Olsen, Vice President
Montana Hospital Association

The Montana Hospital Association supports Senate Bill 394. We do so for several reasons.

Senate Bill 394 regulates the conduct of utilization review performed by health insurers and other third party payers. Currently, hospitals and physicians must tolerate countless reviews and audits without any written or formal standards to guide that review.

Senate Bill 394 specifies reasonable standards for utilization review. These standards are fair to medical providers who are reviewed after the fact. Senate Bill 394 also protects patients by providing reasonable oversight to insurance denials. Currently, when an insurance company denies coverage for a service the patient must pay the medical provider.

Utilization review is performed by companies from all over the country. Hospital claims are usually held in limbo while nurses and doctors representing insurance companies review medical records. These reviews are often done by reviewing medical records sent through the mail. Hospitals are not informed of the review criteria used by the review agency nor of the credentials of the reviewers.

If a hospital or physician disputes the process the claims for payment are simply not processed.

Utilization review can be a valuable process to a medical provider. Opinions about the appropriateness of treatment usually work to prove the delivery of care. Too often, however, utilization review by insurers is a form of harassment.

Utilization review agencies justify the cost of their services by denying medical payments. Senate Bill 394 makes sure that the process if fair to all parties.

MHA urges your support of Senate Bill 394.

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John Solheim
Glendive
Chairman-Elect
John A. Guy
Helena
Immediate
Past Chairman
William J.
Downer, Jr.
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Tim Russell
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William T. Tash
Dillon
James Paquette
Billings
Lane Basso
Billings
Lawrence White
Missoula

Saint Vincent Hospital and Health Center

SENATE BUSINESS & INDUS...
EXHIBIT NO. 7A
DATE 2/20/91
BILL NO. SB394

February 20, 1991

TO WHOM IT MAY CONCERN:

We at Saint Vincent Hospital and Health Center are in full support of Senate Bill 394. This Bill will regulate the conduct of Utilization Reviews by health insurers and/or other third party payors. We support this bill for the following reasons:

* The growth in private Utilization Review companies has doubled over the past two years.

* Hospitals and physicians are being called, sometimes even harassed, regarding the care patients are receiving, whether it be in the hospital or regarding various procedures which are being done.

* We feel Utilization Review is appropriate. However, the problem with the private Utilization Review process is that there are no standard guidelines. Every Utilization Review firm contacts the physician and/or hospital, and asks the questions they feel are appropriate. If they do not get the answers, or if the UR process as each company has defined it is not followed, the insurance company does not pay for the patient's hospitalization and/or procedure. Many times, the patient does not understand the entire Utilization Review process that has been entered into by various insurance companies.

As you can see from this process, the Utilization Review takes place over the phone. We, as healthcare providers, do not know the credentials of the personnel performing this review and/or if they have the appropriate knowledge to perform this process. There is also no knowledge regarding any appeal process. Our objective in supporting this bill is to bring about guidelines and a level of uniformity and appropriateness in the conduct of Utilization Review. In the Medicare and Medicaid sector, this review process is very well done. In the private sector, this process has not been defined or given guidelines.

Our first and most important concern is for that of the patient. The patient needs appropriate healthcare and needs to be guaranteed confidentiality.

We, as a Hospital, believe in Utilization Review. However, we do believe there need to be established guidelines.

Sincerely,

Rita Turley
Vice President
Patient/Health Services

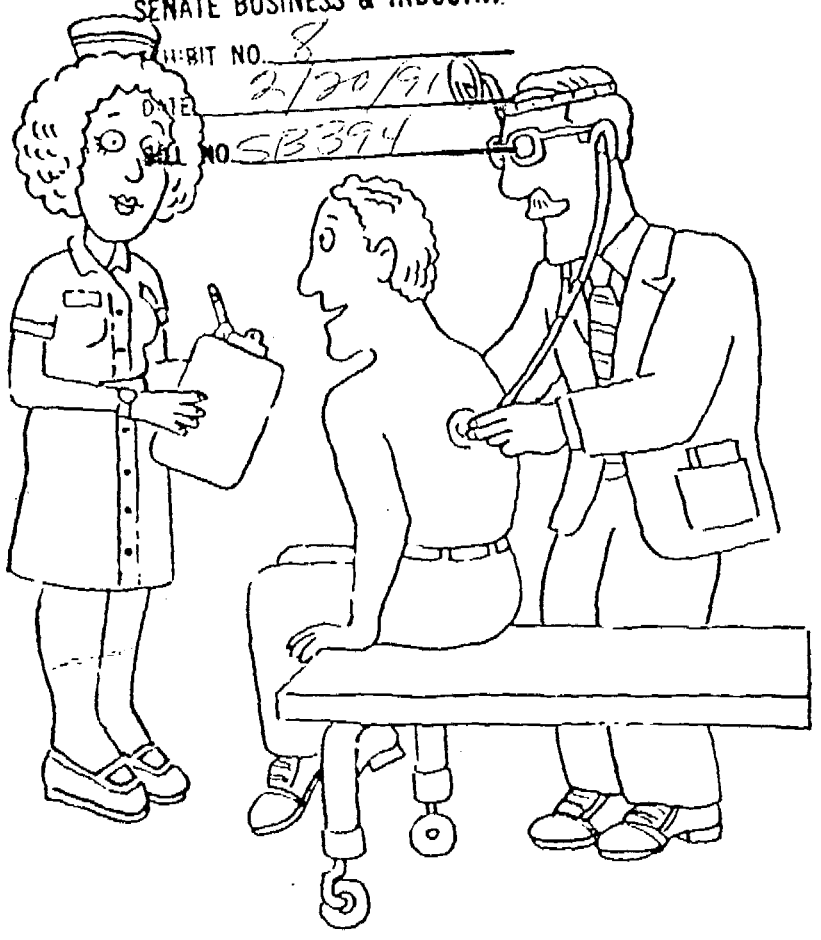
RT:bm

Post Office Box 35200
Billings, Montana 59107-5200
406-657-7000

We touch your life.

MANAGED CARE MONTANA®

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 8
DATE 2/20/91
BILL NO. SB394



Working with you to control cost.

- Preadmission Review
- Continued Stay Review
- Emergency Admissions
- Large Case Management
- Patient Information and Education
- Other Cost Containment Features

Toll-Free Managed Care Line:
1-800-635-5271 or
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Blue Cross Blue Shield of Montana

Managed Care Montana—working together for *your* quality medical care.

Managed Care Montana will help you control costs of your medical care, without sacrificing the quality of the care you need.

Blue Cross and Blue Shield of Montana will work with you when you must be hospitalized to contain the cost of inpatient hospitalization charges. There are no forms to fill out—we have installed a toll-free phone number for you to do your part in helping to control rising medical costs.

Just call 1-800-635-5271 or 444-8550 (in Helena):

- when possible, two weeks before scheduled non-emergency, inpatient hospitalization, or
- within 24 hours after a hospital admission for an emergency.

As a member of Managed Care Montana, you will be working with your physician, the hospital and Blue Cross and Blue Shield of Montana, to control the costs. But the responsibility of notifying us about admission rests with you as the member. If YOU fail to call within the time limit specified in this brochure, benefits will be reduced by $200.

The Review Process

Preadmission Review

When your doctor recommends hospitalization, you need to notify us approximately two weeks prior to the admission.

Our telephones are staffed by registered nurses who have been trained to quickly review each admission. They will certify the admission and approve a length of stay for benefit coverage. You, your physician and the hospital will receive a written notification of the admission certification.

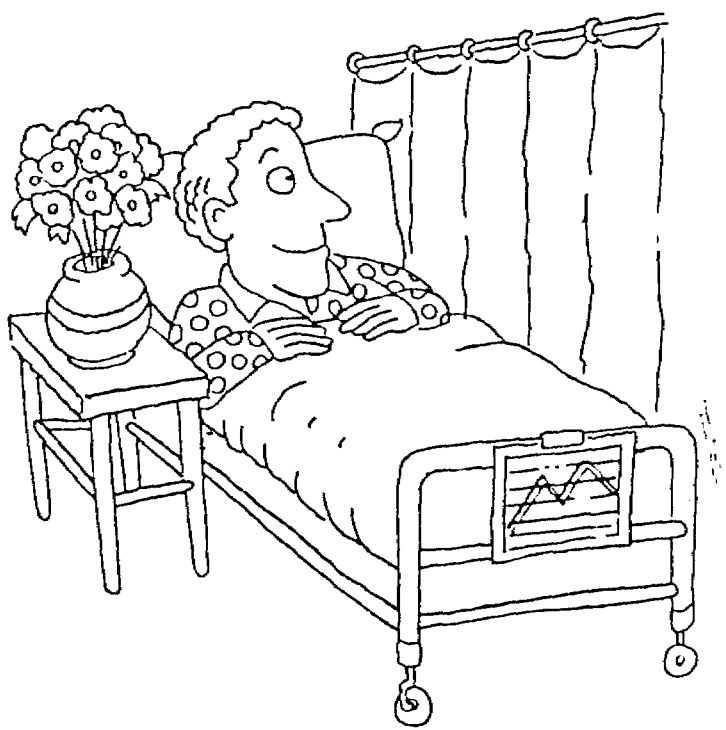
If needed, we will review cases with our Managed Care Montana Medical Director. He will be assisted by a panel of consulting Montana physicians in various specialties including obstetrics and gynecology, orthopedics, surgery, ophthalmology, etc.

Continued Stay Review

Prior to your last certified hospital date, our Managed Care Montana nurse reviewer will contact the hospital to confirm your discharge. If your physician recommends continued inpatient hospitalization, your physician will be contacted for additional information regarding your condition.

When our Managed Care Montana Medical Director or a consulting physician determine that continued hospitalization is not required, the nurse reviewer will call you or your representative and the hospital to inform them of the decision.

If you or your physician do not agree with the recommendation, you are urged to call us to request an appeal. Our staff will assist you through the process, contacting your physician for information.



In an emergency

In an emergency, we recognize that it's important to start treatment immediately. If hospitalization is required, the patient or a family member should call within 24 hours after the admission, or during the next working day.

It's that simple

If you know you will be going to the hospital, you can take a few minutes to arrange for the certification. Before you call, have your membership card ready by the telephone.

For prompt and efficient assistance, please give the nurse reviewer the following information when you call:

- the subscriber's name and certificate number
- the patient's name and telephone number
- the physician's name and telephone number
- the hospital's name and telephone number

The nurse reviewer will ask you questions about the hospitalization. If you are unable to answer the questions, she will then contact your physician.

Large Case Management

If you are facing a potentially lengthy, high-cost medical problem, we will work with you and your physician to recommend quality cost-effective alternative treatment settings. In some cases we may approve coverage for care that is not normally covered by your benefit plan.

By working with you and your entire health care team—physician, other health care providers, hospital personnel, and community support services, we can help you receive quality care at a substantial cost savings.

Patient Information and Education

Our Patient Information and Education Service was created to help you understand exactly what Managed Care Montana can do for you.

It can provide you with information about your health service options, alternate care services, identification of Blue Cross and Blue Shield Member Physicians and support services in your local community. Our nurse reviewers also can provide you with information on medical terminology and procedures and guidance in obtaining the latest medical technology information.

Our Managed Care Montana nursing staff will *not* choose health care services for you. This advice will be given by your physician. However, we want to provide you with a better understanding of your choices.

Other Cost Containment Features

Provider Self-Audit Program.

Occasionally there are errors made in provider billings. A careful review of your health care bills may result in significant savings. Blue Cross and Blue Shield of Montana will refund you 50 percent of the savings, up to $1,000 per hospital stay or other provider billing, based on an overcharge of $2,000. Please call the Managed Care Montana toll-free number for instructions.

Short-Stay Maternity Incentive.

When the mother is eligible for maternity benefits and both the mother and baby are discharged after an inpatient stay of only one day following a routine hospital delivery, the subscriber is eligible for a cash incentive payment of $150. The early discharge must be approved for both mother and baby by the attending physician. If you qualify for this payment, please obtain the Short-Stay Maternity Incentive form from your employer or any Blue Cross and Blue Shield office and mail to:

Blue Cross and Blue Shield
of Montana
Attention: Claims Department
Short-Stay Maternity
Incentive Program
P.O. Box 4309
Helena, MT 59604-4309

Generic Drug Program.

Purchasing generic drugs rather than brand-name drugs can save up to 50 percent of the cost of prescription medication. Ask your physician about generic drugs whenever a prescription is written for you.

Generic drugs are payable at 100 percent of the charge, after your deductible is met. Brand-name drugs are payable at 80 percent, after deductible. Filing forms for prescription drug claims are available through any Blue Cross and Blue Shield office and many pharmacies. You must file your own claims. There is a place on the filing card to indicate if it is a generic drug. Please have the pharmacist sign the card or attach the prescription receipts to the card.

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1-800-635-5271 or 444-8550 (in Helena)

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Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

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12/88

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

STAN STEPHENS, GOVERNOR

ROOM 130, MITCHELL BUILDING

STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 9
DATE 2/20/91
BILL NO. SB394

Testimony on SB394
Before the Senate Business and Industry Committee
by the Department of Administration
February 20, 1991

Mr. Chairman, Members of the Committee, I am Joyce Brown, Chief of the State Employee Benefits Bureau, with the State Personnel Division, Department of Administration.

I am here to oppose SB394 which will adversely impact the 28,000 State employees, retirees, legislators and dependents on the State health plan.

State government, Montana's largest employer, is not able to fund cost increases for existing employee health benefits. Smaller employers are dropping health benefits altogether because of rising costs. Pay proposals for State employees currently being considered, provide less than half of the funds needed to cover projected cost increases for the coming biennium, leaving the State health plan $9,000,000. We will have to cut $9,000,000 worth of benefits or collect another $9,000,000 in premiums from our employees. If we collect the $9,000,000 in additional premiums it will wipe out pay proposed pay increases of employees in lower paying positions.

The State plan like all health plans is facing a health care crisis and this legislation makes matters worse.

The State plan is self-insured and through contract hires Blue Cross and Blue Shield of Montana to do two things: (1) Process claims and (2) provide managed care to help control costs. Utilization review is an important part of managed care which would be crippled by the burdensome regulation this legislation imposes.

We hire Blue Cross and Blue Shield to review the appropriateness of care precisely because they have the medical personnel to assure that State plan dollars are not wasted on high-cost alternatives such as inpatient care when there are equally effective lower cost alternatives available, such as out-patient care. In an atmosphere of shortage, we need to make every dollar count, and our third-party payor is the most appropriate organization to accomplish that.

Please refer to the attached article by the Attorney General of West Virginia published in the Journal of State Government by the Council of State Governments. One of the primary recommendations

to other States for controlling health care costs is to encourage and implement programs that place the third party payor (in our case Blue Cross\Blue Shield) in the shoes of the consumers to help obtain cost-effective health care. The author states "Insurers have the ability to employ the expertise needed to restrict payments to necessary treatments and tests..benefit management programs also are safeguards against unneeded procedures and treatment.

We urge you to defeat SB394 which would cripple precisely those efforts to control costs that the Council of State Governments recommends.

EXECUTIVE ACTION ON SENATE BILL 316

Motion:

Senator Noble made the motion to table SB 316.

Discussion:

Senator Thayer stated that he is compelled to support the bill after hearing the testimony. The problem that he is having is a bill of this nature, this late in the game, with amendments that are pretty far reaching. His own local hospital is concerned about something like this considered this quickly he asked that the bill be tabled to give the people the chance to get together.

Amendments, Discussion, and Votes:

None

Recommendation and Vote:

The motion to table SB 316 passed 5 to 4 votes.

EXECUTIVE ACTION ON SENATE BILL 394

Motion:

Senator Franklin moved to reconsider the tabling of SB 394.
Senator Franklin moved to do pass SB 394 as amended.

Discussion:

Senator Thayer stated that they have had more people come in and oppose this that represented all of the big groups in Montana. They all had very convincing arguments, and he doesn't know that the amendments will fix it. Typically that late in the session when you have that much confusion, he thinks that the bill should have stayed in the committee where it laid comfortably.

Senator Noble stated that he feels because there was so much heat on both sides of this that there is a problem. This should be worked out by all people over a period of time so that we're are doing the right thing.

Amendments, Discussion, and Votes:

None

Recommendation and Vote:

The motion to reconsider the tabling of SB 394 passed 6 to 3 votes.

The motion to do pass SB 394 as amended passed by 6 to 3 votes.

ADJOURNMENT

Adjournment At: 11:45 a.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JDL/dia

ROLL CALL

BEI COMMITTEE

DATE 2/22/91

LEGISLATIVE SESSION

NAME	PRESENT	ABSENT	EXCUSED
BRUSKI	X		
FRANKLIN	X		
GAGE	X		
HAGER	X		
NOBLE	X		
THAYER	X		
WILLIAMS	X		
KENNEDY	X		
LYNCH	X		

Each day attach to minutes.

ROLL CALL VOTE

SENATE COMMITTEE B & I

Date 2/22/91 Bill No. SB394 Time 10:00

NAME	YES	NO
WILLIAMS	X	
THAYER		X
NOBLE		X
HAGER	X	
GAGE		X
FRANKLIN	X	
BRUSKI	X	
KENNEDY	X	
LYNCH	X	

D ANDERSON
Secretary

J A LYNCH
Chairman

Motion: DO PASS AS AMENDED

SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:
We, your committee on Business and Industry having had under consideration Senate Bill No. 394 (first reading copy -- white), respectfully report that Senate Bill No. 394 be amended and as so amended do pass:

1. Title, lines 13 through 15.
Following: ";" on line 13
Strike: remainder of line 13 through ";" on line 15

2. Title, line 17.
Following: ";"
Insert: "AND"

3. Title, line 18.
Following: "RULES"
Strike: remainder of line 18 through "DATE"

4. Page 1, line 22.
Strike: "8"
Insert: "7"
Strike: "requires"
Insert: "authorizes"

5. Page 1, line 24.
Strike: "10"
Insert: "9"

6. Page 2, lines 5 through 7.
Strike: subsections (1) and (2) in their entirety
Renumber: subsequent subsections

7. Page 2, line 17.
Strike: "10"
Insert: "9"

8. Page 2, line 22.
Strike: "10"
Insert: "9"

9. Page 3, line 10.
Strike: "10"
Insert: "9"

10. Page 3, line 22.
Following: ";"
Insert: "and"

11. Page 3, line 25 through page 4, line 2.
Following: "employment" on line 25
Strike: remainder of line 25 through "services" on page 4, line 2

12. Page 4, line 14.
Following: line 13
Insert: "(5) "Utilization review agent" means a person or entity performing utilization review except an agency of the federal government or an agent acting on behalf of the federal government to the extent the agent is providing services to the federal government."

13. Page 5, line 1.
Following: "care"
Insert: ", except that a utilization review plan for health care services under the general relief medical assistance or medicaid programs provided for in Title 53 need not reflect community standards of care"

14. Page 5, line 19.
Following: ";"
Insert: "and"

15. Page 5, lines 20 through 21.
Strike: lines 20 and 21 in their entirety
Renumber: subsequent subsection

16. Page 5, line 24.
Strike: "10"
Insert: "9"

17. Page 6, lines 4 through 8.
Following: "determination" on line 4
Strike: remainder of line 4 through "relating" on line 6
Insert: "by a utilization review agent as"
Following: "appropriateness"
Strike: remainder of line 6 through "determination" on line 8
Insert: "of an admission, service, or procedure must be reviewed or determined in accordance with standards or guidelines approved"

18. Page 6, line 14.
Following: "relevant"

Strike: "specialty or subspecialty"
Insert: "area of health care"

19. Page 6, line 20.
Following: "has"
Strike: "consulted"
Insert: "made a reasonable attempt to consult"

20. Page 7, line 14.
Following: the second "of"
Strike: "the"
Insert: "all relevant"

21. Page 7, lines 15 through 23
Following: "review" on line 15.
Strike: remainder of line 15 through "person" on line 23

22. Page 7, line 24 through page 8, line 3.
Strike: section 7 in its entirety
Renumber: subsequent sections

23. Page 8, line 5.
Following: "commissioner"
Strike: "shall"
Insert: "may"

24. Page 8, line 6.
Strike: "10"
Insert: "9"

25. Page 8, lines 8 through 10.
Strike: subsections (1) and (2) in their entirety
Renumber: subsequent subsections

26. Page 8, line 18.
Strike: "10"
Insert: "9"
Following: "preempted"
Insert: "or duplicated"

27. Page 8, line 20.
Strike: "10"
Insert: "9"

28. Page 8, line 21.
Following: "preempted"
Insert: "or duplicated"

29. Page 8, line 23.
Following: "preemption"
Insert: "or duplication"

30. Page 8, line 25.
Strike: "10"
Insert: "9"

31. Page 9, line 16.
Following: "provider"
Insert: ", including an in-house utilization review that is conducted by or for a long-term care facility and that is required by medicare or medicaid regulations,"

32. Page 9, line 17.
Strike: "10"
Insert: "9"
Following: "not"
Insert: "directly"

33. Page 9, line 21.
Strike: "10"
Insert: "9"

34. Page 9, line 23.
Strike: "10"
Insert: "9"

35. Page 9, lines 24 and 25.
Strike: section 12 in its entirety

Signed: _____
John "J.D." Lynch, Chairman

2/22
Amd. Coord.

SB 2/23 8:25
Sec. of Senate

The rainy day is here, and the corpus of the Coal Tax Trust Fund should be used. HB 664 diverts the interest the State is being run on. That money is going to have to be replaced by this Legislature. As a result he can't support it.

REP. SHEILA RICE spoke in favor of HB 664. She didn't disagree with any of the amendments because they deal with the dollars. These amendments are legitimate uses of general fund or Coal Trust earnings that bring jobs and dollars to the State of Montana, and therefore these amendments should be passed.

Mr. Verdon referred to the amendments, one amendment provides $400,000 to the Montana Entrepreneurship Center which is not an entity described in the Code anywhere. If it is used for the MEC, another subsection should be provided saying as used in this section 'Montana Entrepreneurship Center means...' and use the language in **Ms. Lutz's** definition of the 'Montana Entrepreneurship Center which is a cooperative effort of the University of Montana, Montana State University, and Eastern Montana College, and uses the strengths of all six units of the University system to address business development and economic diversification by creating the infrastructure necessary to encourage and support entrepreneurship and small business development.' He suggested that definition be included in this amendment.

Motion: REP. PAVLOVICH moved the proposed amendment be adopted.

REP. TUNBY said the title of the bill says 'An Act to extend the appropriation made by Chapter 634, Laws of 1989'; just how was that appropriated before in 1989? **REP. RICE** answered in 1989 it was appropriated from the 15% of coal trust earnings which were then undesignated. Today that 15% is now allocated to the school foundation program. HB 664 would be funded out of the 85% coal trust earnings that go to the general fund, so it would affect the general fund if passed and funded.

REP. KILPATRICK reminded there is another bill coming. HB 664 does have to go to Appropriations. It is a good bill, but Appropriations might not approve.

Vote: Motion to adopt the amendments was passed with REPS. KNOX, STEPPLER, STELLA JEAN HANSEN voting No.

Vote: Motion HB 664 Do Pass As Amended was adopted with REPS. KNOX, STEPPLER, ELLIS, TUNBY, STELLA JEAN HANSEN voting NO.

HEARING ON SENATE BILL 394

Presentation and Opening Statement by Sponsor:

SEN. PAUL SVRCEK, SD 26, Thompson Falls, stated SB 394 regulates utilization review which is a process whereby health care

insurers review medical procedures as to whether they are appropriate for coverage. None of the people who will testify today are against utilization review. Some difficulties have arisen lately whereby some of the procedures that people thought they were being covered for have been denied. It has been unclear why and the reasoning has not been completely forthcoming. This bill sets down some standards. It is an Act to regulate the conduct of utilization reviews by health insurers and other third-party payers; to prohibit a person from conducting utilization reviews unless the person maintains with the Commissioner of Insurance a utilization review plan; to protect patients and health care providers in the conduct of utilization reviews by requiring concurrence of a physician in a determination relating to the necessity or appropriateness of health care services rendered to a patient; to provide for the appeal of an adverse decision resulting from a utilization review; and to authorize the Commissioner of Insurance to adopt rules.

Section 1 states the Purpose. Page 3, (4) essentially is the purpose of the bill to protect the patients, employers, and health care providers by ensuring that utilization review results in informed decisions. This bill is mostly about allowing the purchasers of health care insurance to be informed when they are making their decisions about the purchase of that health care about what is available for coverage and what is not. The definition (4) on page 4 is a good definition of utilization review. Section 3 is the Utilization Review Plan. This essentially requires all health care insurance providers to file a plan with the Commissioner of Insurance stating to the public how they will conduct their utilization reviews.

On Page 5 Medicaid has been accepted. It is difficult at best to bring them into this system. Section 4 sets down the standards by which utilization review must be conducted. The review must be done if at all possible in consultation with the patient's physician. There will be some amendments in this area that will clean this provision of the bill up a little more.

Section 7 is a rule making section. Section 8 is a preemption of federal law. Anything that governs this area in federal law will be preempted. Section 9 is the application. Section 10 is for codification.

Pat Melby will explain the amendments in more detail. There was a mixup in the hearing in the Senate. The Blue Cross and Blue Shield especially was not in favor of the original bill. Work has been done with the providers. Some amendments were acceptable to the Senate. During the last week some of the unclear things in the Senate have been cleared up. If the amendments offered today are adopted, everyone will be comfortable with the bill.

Proponents' Testimony:

Pat Melby, Rimrock Foundation, said they had some amendments **EXHIBIT 10** There was quite a free for all in the Senate hearing in the Business & Industry Committee. Since that time they have been working with Blue Cross Blue Shield and the Health Insurance Association of America, other insurance interests, provider interests to come up with amendments to this bill that would make everybody comfortable. These amendments would make this a compromise bill. Some people may not be entirely happy with this language and feel that it may be subject to interpretation, but this is the best to be accepted for two sides who are quite a ways apart on what utilization review is. The fiscal note shows Medicaid to be a problem. The amendments proposed will eliminate any fiscal impact Medicaid would have been caused by this bill.

Amendment #1 was requested by the Health Insurance Association (HIA) of America. It makes clear that utilization review does not include routine claims review to determine if there is even coverage for a claim. Amendments #2 through #9 eliminate the requirement that all these reviews have to be done by a physician. That was in the original bill. These amendments provide that on the final review that is done by the managed care agency, there is an initial review done that advises a patient their claim is going to be denied. They have the opportunity to appeal or ask for a reconsideration of that claim by the insurance company. That review has to be done by a health care professional trained in that relevant health care area rather than a physician having to review it when it is in a different field of health care. They also provide that before a final denial is made, they should make a reasonable attempt to consult with the health care provider that is treating the patient. If they are going to deny the claim, they should put the reasons for that down in writing, and those should be made available on request.

Amendment #10 gives the insurance company flexibility to give a patient at least 30 days to appeal. Amendment #11 is an amendment requested by Blue Cross Blue Shield as well as by Medicaid to give them a little longer time in which to make a final decision after they review all the medical records.

David Cunningham, Director of Rimrock Foundation, urged support of SB 394. It is an important key piece of legislation. The object of this bill is to bring reasonable business practices to the conduct of utilization in review which is a relatively new, totally unregulated process in Montana designed to reduce unnecessary medical expenses. Everyone is in favor of the goal of reduction of medical expenses where possible. The means and procedures by which such a goal is achieved is the subject of SB 394. It seeks to assure that in conducting utilization in review for medically necessary services, insurance companies do not engage in unquestionable practices or practices which create economic barriers to medically necessary care. Some companies in Montana currently are using practices which cause great concern at this point. It is not uncommon to have a nurse without

training or experience in the treatment of chemical dependency deny admissions for the treatment of chemical dependency even though a physician has diagnosed an individual patient as being chemically dependent. In too many instances utilization review companies are using criteria which have no foundation in research and which are clearly intended to be economic barriers to care. The clinical needs of the patient are not the primary concerns of these companies. Cost containment is their central goal even though the patient is insured for those services. SB 394 seeks to bring utilization in review firms under the auspices of the Insurance Commissioner's office and it does basically four things. It defines that we utilize nationally recognized criteria, it requests that those criteria are published, that reviews are conducted in a timely manner, and trained professionals are used in the area in which they are going to be reviewing. This bill requires reasonable business practices in the conduct of utilization in review. It seems only reasonable to expect this of a company that has the power to deny medical services. They do not believe the patients who have purchased insurance should have the courts as their only resort in a matter like this. Please support SB 394.

Jim Ahrens, President of the Montana Hospital Association which represents 56 member hospitals, supports SB 394 as amended. About every week they get a call at the Association on this issue. People are legitimately looking at health care bills and costs. A lot of times those reviewers are not known and neither is their criteria known when they review the claims. Obviously they are not opposed, it is good business practice. The way the bill is set up and the criteria is being set up and established, at least they will be able to look at those ahead of time and understand what is going on. They also would be able to identify once and for all who the companies and people are who are almost waltzing in and out of the hospitals at will asking for records and costs and charts, and such things. People have a right to know and to check out their hospital charges and bills. This sets up a reasonable process for this to take place. It looks at costs, at quality, and everything is reviewed. The system makes a lot of sense as it has been presented in this legislation.

Ann Bellwood, Director of the Rocky Mountain Treatment Center in Great Falls, passed out **EXHIBIT 11** which appeared in one of the counselling magazines and, although it is a comedy farce and very amusing, unfortunately they are finding this farce is actually occurring on a daily basis in many cases where the process that is taking place is comical. The only problem is that it is dealing with human lives and serious illnesses which makes it no longer very amusing. They have experienced a number of problems along these lines where they were dealing with someone who didn't have any kind of understanding of what they were reviewing, they didn't have an understanding of what Montana conditions are. They are running into imposition of standards for outpatient care for instance that may be appropriate for an urban area where there are lots of outpatient treatment places available, yet they try

to impose the same standards on us and say the patient needs to go to outpatient; they don't care if there is no outpatient facility for them, saying that is their problem, it is not ours. She urged support for SB 394. It is an important step in helping ensure that Montanans get the appropriate health care they deserve.

Mona Jamison, Legal Counsel and Lobbyist for the Rocky Mountain Treatment Center, summarized the significant aspects of SB 394. She explained utilization review. It is the determination by your insurance company whether or not the medical service that you received is appropriate and necessary. Utilization review is conducted by the insurance company when your claim is filed by your physician or by yourself or by any other health provider. They are saying was this treatment appropriate and necessary? Why is this bill in here? This bill has been introduced because claims have been denied, consumers are confused, the battles have increased between the insurance companies and third-party payers, and the consumers are the insureds regarding these policies. The consumers believe many times a certain treatment or certain service was covered in an insurance policy, and the insurance company is saying No it wasn't covered or perhaps this was the inappropriate kind of treatment or level of treatment. So you end up creating what has been created, particularly during the last year or two, with bad will between consumers and the people who pay their claims. Obviously you can understand why that would happen when we think we have an insurance policy that is going to cover something and then we are told No it doesn't because of some fine print in the insurance contract or even in interpretation that no one reasonably even suspects could be made from the language.

This bill requires the filing of a utilization review plan. That is probably the most significant part of this bill. The bill requires the third-party payer or the insurance company to file a plan with the Insurance Department, listing what the criteria and standards are that will be utilized to determine whether or not specific claims are reasonable, necessary and fair. This is a bill of disclosure. State agencies are required to not only file their rules that affect citizens when they take certain actions or try to get licenses and actually make them go through a notice and public hearing situation or process. This bill requires the insurance company to file with the Insurance Department those standards they will use in determining whether or not your claims are valid or not. That is all it is. It's a bill of disclosure. The bill actually benefits the consumer and the insurance company. Once the criteria and standards for review are filed and published so the insurance company is actually required to think through the process if they haven't and file their plan, then the consumers can actually see what they are, that the mere disclosure and knowledge of what those standards are will diminish a lot of the battle and bad will that has been created by not knowing what those standards are. That will go a long ways to improving the relationship between the insureds and the

insurance companies.

The other important aspect of the bill in addition to the number one aspect of filing the plan is that the conduct of utilization review is regulated to a certain minimal extent. **Mr. Melby** has explained who will be doing the review by insurance company and third-party payers regarding your claims if it was submitted for a particular procedure. They support this bill, believe it is a consumer bill, it is a fairness bill, and in the long run it will actually improve the relationships between the insureds and the third-party payers.

Larry Fasbender works for the Chemical Dependency Programs of Montana. This is an important piece of legislation to let everyone know what the rules of the game are before they start the game. In any situation whenever there is that in existence in advance all of the parties are going to be much happier. If this legislation goes towards alleviating a lot of problems that would arise otherwise, that in itself is an important enough reason to pass this legislation. It will do that. It will allow everybody to know the rules under which they are playing so they have an understanding going in what is going to be paid for, how it is going to operate, the standards that are going to be used. It is important SB 394 be passed so there is not a lot of consumer concerns as well as provider concerns because of not knowing what those rules are.

Dolores Deyerle, Manager of Medical Information Services Department at St. Peter's Hospital, Helena, explained one of the functions of that department is to provide utilization review. Within the hospital that is done on a concurrent basis to certify the admission of a patient to a facility. Utilization review is very definitely a patient's service because patients subscribe and enroll in an insurance plan assuming their hospitalizations are going to be reimbursed. However, a staff of RNs communicating that information to utilization review companies does not always know under what criteria they are working. It certainly behooves all of us to control health care costs and it is apparent when so many return calls are needed to communicate the type of information that are necessary to get an admission certified. If there could be very distinct criteria known as to what the companies were using to certify admissions, that would reduce their time in the process and reduce the reviewer's time in the review company. That ultimately has to contain health care costs. She was speaking in support of SB 394.

Mary McCue, representing the Montana Mental Health Counsellors Association which is a group of licensed professional counsellors most of whom are in private practice in Montana, supports this bill because there have been certain instances when claims have been denied for services they provide, and it is not always clear why they were denied. It will be beneficial to have this plan on file at the Commissioner's office so they can learn more about how the process is carried out. They particularly support the

amendments, specifically the one that changes the language in the bill from physician to health care professional with experience in the relevant area because as the bill is currently written it would always be a physician who would be reviewing that adverse determination and they feel strongly because they are providing mental health services, it is necessary to have that language in the amendment **Mr. Melby** presented.

Dave Barnhill, Deputy Insurance Commissioner, supports this bill. It would make the Insurance Department a clearing house for the dissemination of basic information to consumers so they could look out for their own interests. That would be the most effective and cost efficient form of regulation.

Steve Brown represents Blue Cross Blue Shield of Montana and supports SB 394 as amended. Blue Cross Blue Shield has a utilization review program called Managed Care Montana. He emphasized the procedures required in this bill are already in their Managed Care program. Included in those procedures was an opportunity for the providers to comment on that Managed Care program before it was implemented. Managed Care is an important part of the effort to control health care costs because without a managed care program if unnecessary treatment is provided or treatment is not provided in the appropriate setting, who pays for those excess health care costs? You do. The consumer will be faced with that dilemma in your very own health program this year for state employees which also applies to each Legislator. They are $9-11 million in the hole. Why is it important? Simply because regarding the question of appropriate treatment setting, if outpatient alcohol mental counseling works, the figures Blue Cross Blue Shield has indicated, that treatment can be provided at a cost of several hundred dollars vs inpatient costs which can be as high as $8,000 per case. So it becomes important for there to be a legitimate viable managed care program to help deal with those cost concerns. He thanked **Pat Melby** and **Tom Hopgood** for working so diligently and supported these amendments offered.

Opponents' Testimony:

Roger Tippy, representing the Montana Dental Association, said the dentists like any other provider group can see what the proponents have been talking about and would be as unhappy as any other provider to learn some insurance company had a person who wasn't a dentist deny all or 80% of a claim for reimbursement. This bill is confusing and hard to read. He hoped the Committee would get a grey bill worked up through a subcommittee appointment so it could be more clearly viewed. Sections 4 and 9 read together are confusing. Section 2 (4) is a very broad definition of utilization review even with **Mr. Melby's** amendments. That covers a lot more than the applicability Section 9 purports to cover. Dental peer review is taken in in Section 2 (4), and tries to say in Section 9 that it is out.

What is dental peer review? It is one of the most successful

recognized ways of starting out with mediation if a dental patient or a third-party reimburser has a problem with what the dentist has provided to the patient. You can ask for peer review if a dentist has not provided satisfactory service. Initially a form of mediation is determines if there were unforeseen problems that in good faith could not have been anticipated at the outset and whether the fee should be adjusted. Whether the care was appropriate is also within the scope of dental peer review. The proponents don't want to cover dental peer review even though third-party providers can access and utilize it. The applicability Section 9 Exemptions doesn't seem to provide any exemptions. One is needed there. This peer review process, committees of dental peers, is conducted on behalf of (a) a Montana business entity, on behalf of the dental association which has a nonprofit health service plan. You cannot write down too easily in a book in black and white like the diagnostic research groupings that the hospitals use that you should always be able to straighten a teenager's teeth in eight months if it is not an overbite or occlusion of more than X%. The peers have to apply some subjective factors to that and look at all the considerations that apply to a given case. They feel they don't know how you would get from the ADA in Chicago one short brisk set of standards that would say in every case 'this should be time enough to cure the problem'. He thinks the means of the bill are laudable. He doesn't want it to not pass but does think a grey bill subcommittee examination might benefit it best.

Dave Hartman is Executive Secretary with the Montana Education Association. He has prepared testimony in opposition to SB 394 **EXHIBITS 12 and 12A.** It was prepared before receipt of the amendments offered to the third reading copy; however, some of it is still relevant. He was impressed by the people behind him who are representatives of health care providers and health insurance industries serving Montana. Health care providers have historically opposed utilization review programs because those providers, whether hospitals, chemical dependency treatment centers, family physicians, or surgeons don't want folks looking over their shoulders and second guessing their decisions about courses of treatment, types of treatment and the expenses and costs associated with those treatments. They don't want people saying wait a minute. For the particular condition under consideration you proposed a course of treatment that is going to cost $10,000. Upon utilization review it is determined there is an equally effective procedure available for $1,000. We are talking profit in many cases. Who is benefitted? The consumers of health care services in Montana are not represented here today. The people of Montana including the 8,500 members represented by the Montana Education Association, many, many of whom have agreed through their local unions in cooperation with their employers to implement utilization review programs that save them premium dollars.

When health care providers are supporting a bill addressing utilization review, a process they have historically opposed and

resisted, he becomes a suspicious consumer of health care services. His suspicions have been assuaged in part by the numerous amendments offered. But there is still a flaw from a consumer's point of view, and that is the very restrictive nature of SB 394 even in the form which the amendments would recreate it. There is still reference for the need for utilization reviews to be conducted by health care professionals. The vast majority of utilization reviews are performed by registered nurses using the procedures and criteria laid down by physicians. The reviews and the reviews upon appeal are not traditionally conducted by physicians. Under SB 394 they are to be conducted by health care professionals, and specifically in proposed amendment #4 health care professionals trained in the relevant area of health care. If the Committee were to focus on amendments #4 and #7 and replace the phrase 'health care professional' with 'utilization review agent' the consumers of health care services in Montana who elect to participate in utilization review procedures would be well served because an effect of this bill even with the amendments is to very greatly restrict access to utilization review services.

The Health Insurance Industry of America has been represented here. The fact of the matter is the Health Insurance Industry of America does not represent those national firms that provide utilization review and case management services, many of whom provide those services in Montana. He urged consideration of that point to substitute the phrase 'health care professional' with 'utilization review agent', mindful that utilization review agents may well be registered nurses who currently provide these services day in and day out using the guidelines established by physicians.

Related to those observations, the term 'health care professional' as now appearing in SB 394 and is referenced in the amendments, there is no definition of health care professional in this bill, and none has been offered in the amendments.

Mary Dalton, Primary Care Bureau Chief in the Medicaid Services Division of the Department of SRS, read EXHIBIT 13. The Department, in consultation with appropriate health care professionals, already has developed standards to control its utilization review activities, and the provisions of this bill are unnecessary with respect to Medicaid and state medical programs and should be exempted from the provisions of this bill.

Larry Akey represented the Montana Association of Life Underwriters. Their Association uses utilization review as a way of trying to hold the line of spiraling health costs to the health consumer in the State. As originally introduced SB 394 would essentially gut utilization review for commercial health carriers. He commended the sponsor and the proponents of this bill in trying to work with the industry to come up with a bill that would address some of the concerns expressed by the proponents without eliminating utilization review for commercial

carriers. They believe Draft #4 submitted by **Mr. Melby** goes a long way to solving those concerns. Although they cannot in good conscience appear as proponents to SB 394, if the proposed amendments are adopted, their opposition will melt away.

Tom Hopgood representing the Health Insurance Association of America, emphasized support for the remarks made by **Mr. Brown** and **Mr. Hartman** as to the need for utilization review. The reason utilization review is needed is because of the tendency on the part of some providers to overprescribe. Considerable amount of time has been spent working on the amendments back and forth with the various companies and committees within the Association he represents. With the amendments proposed they do not oppose this bill.

Questions From Committee Members:

REP. LARSON asked if anyone from the Workers' Compensation Division was present. There was no one. He found that curious.

REP. BENEDICT also found that curious. You are involved in a lot of legislation that is trying to contain costs in Workers' Comp. One of the things to be seen a lot more of is utilization review of Workers' Comp. Won't this restrict the availability of Workers' Comp to control costs? **SEN. SVRCEK** said absolutely not. All this bill does is set up the rules before the game starts and sets up the criteria by which medical coverage is going to be provided. Presently, to the best of his knowledge, the Division of Workers' Compensation does not make use of utilization review. Perhaps it is a good idea at some point down the line, but this bill has no effect on the Division one way or another. That is probably why they are not here.

REP. ELLIS asked if the amendments she submitted had been talked over with the sponsor. **Ms. Dalton** said they had indicated to **Mr. Melby** they would be asking to be exempt. She had not talked directly to the sponsor. **Mr. Melby** had a meeting yesterday with **Nancy Ellery, Administrator of the Medicaid Division,** and gave her a copy of his amendments Draft #3. She asked for the amendment on Draft #4 submitted today requesting 60 days to do the review instead of 30. **Ms. Ellery** had told him she didn't feel Medicaid should be in the bill. They could live with the bill with the amendments proposed. All of the problems talked about in **EXHIBIT 13** were resolved with the amendments. They were concerned about having physicians review all of the claims even though some of the services are provided by other types of providers. That has been taken care of in the bill. The time period for review has been increased from 30 to 60 days at Medicaid's request in the proposed amendments. He doesn't think their proposed amendments are necessary.

REP. BACHINI asked if she concurred with the amendments made by **Mr. Melby. Ms. Dalton** said **Mr. Melby's** amendments would be acceptable to them, but they preferred to be exempt from this

bill. As a state agency they already file administrative rules.

REP. ELLIS asked why he didn't want to exempt Medicaid from the reviews. **Mr. Melby** advised Medicaid doesn't do their own utilization review. They use independent companies like insurance companies like anybody else does. Medicaid is one of the biggest insurance companies in the State and they probably should be under the same standards as anybody else. They advised him they didn't have any problem with the bill because they already have their criteria and make them available. They already follow the procedures set up in HB 394. He represents some clients he didn't appear on behalf of here today. **Rivendall of Butte** and **Rivendall of Billings** specifically would like to see Medicaid covered under this just so that in the future everybody knows what the rules are and there is some statutory direction, not only to insurance companies and health service corporations, also to state agencies that are providing insurance benefits.

REP. ELLIS asked if you still feel this requires double review. **Ms. Dalton** said she doesn't believe it required double review. It is a double administrative burden. They already file rules that are open to public comment as a state agency at all times. To do this they would have to go through not only their review process and make their rules available through the department, but once again go through the Insurance Commissioner which would double the paperwork on both us and the Insurance Commissioner.

REP. CROMLEY said your proposed amendment would take out 'health care professional' and put in 'utilization review agent', so it would be 'determination by utilization review agent trained in the relevant area of health care'? **Mr. Hartman** said that is an excellent question. Utilization review agent trained in the relevant area of health care would depend on how that was defined. Certainly a registered nurse could be instructed and trained and supplied background information that in a reasonable person's view would cause one to conclude that a registered nurse trained in that area certainly would be knowledgeable in that area. The question has been raised about the application of SB 394 to Medicare and Medicaid recipients.

It is interesting that **SEN. KEATING** is a co-sponsor of SB 394. He is also the chief sponsor of SB 391 which has also come over to the House. SB 391 mandates managed care including utilization review for Medicare and Medicaid recipients because it is recognized that managed care including utilization review saves consumers money, and in this case saves the State of Montana money, thus assuring that necessary medical care is appropriate and is provided in an appropriate setting, and on the other hand SB 394 restricts and limits the opportunity for utilization review and the participation of the people of Montana who are not Medicare or Medicaid recipients to participate in managed care including utilization review.

Closing by Sponsor:

SEN. SVRCEK was not too clear what **Mr. Tippy's** complaints about the bill are. The definition he has problems with comes from utilization review legislation that has been enacted in several other states. It was taken right out of the other statutes. They probably have dentists in those states that would come under the purview of those statutes. If you want to exempt a peer review and even exempt dentists out of SB 394, there are consumers who will come back at them sometime.

He has particular difficulty with the testimony of **Mr. Hartman** from the **MEA.** He testified as if this bill would make utilization review illegal, and nothing could be further from the truth. In my opening I said we agree that utilization review is an important process for containing costs and nothing in this bill would take away utilization review. It is interesting **Mr. Hartman** purports to represent consumers when, if you were to come down on the side he is advocating, the consumers of the health care would be frozen out of the picture altogether. They would have no access to the information about the health care that is being provided them. It would seem judging by his testimony that he is advocating the position of the insurance providers, but even the insurance providers have said they can support SB 394 with the amendments proposed. Specifically **Mr. Hartman** asked the health care provider be changed to a utilization review agent, so in essence there will be a utilization review agent reviewing utilization review. Often he said that person could be a registered nurse. What is unreasonable about having the health care provided by a physician reviewed by a physician? by having the health care provided by a psychiatrist reviewed by a psychiatrist? There is nothing unreasonable about that. If you change the language in the way **Mr. Hartman** asked you to, you may in essence be undercutting the service that is being provided to the consumers he purports to represent.

There are presently in the Insurance Commissioner's office sixteen complaints on file against insurance companies because of the rejection of health care provision that was presumed to be covered. Because there isn't something like this in place, it is not known what the rules are before you go in. Under SB 394 you would know what is covered and what is not. It is a health care consumer bill. He thanked all those people who worked so hard on the amendments which are simple and straightforward and will provide access to health care utilization review.

REP. O'KEEFE will carry SB 394 on the House floor.

HEARING ON HOUSE BILL 795

Presentation and Opening Statement by Sponsor:

REP. HAL HARPER, HD 44, Helena, explained this bill is an Act creating an Infrastructure Trust Fund within the permanent Coal Tax Trust Fund; authorizing the creation of a state debt through

HOUSE OF REPRESENTATIVES

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

ROLL CALL DATE March 15, 1991

NAME	PRESENT	ABSENT	EXCUSED
REP. JOE BARNETT	✓		
REP. STEVE BENEDICT	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. ALVIN ELLIS, JR.	✓		
REP. STELLA JEAN HANSEN	✓		
REP. H.S."SONNY" HANSON	✓		
REP. TOM KILPATRICK	✓		
REP. DICK KNOX	✓		
REP. DON LARSON	✓		
REP. SCOTT MCCULLOCH	✓		
REP. BOB PAVLOVICH	✓		
REP. JOHN SCOTT	✓		
REP. DON STEPPLER	✓		
REP. ROLPH TUNBY	✓		
REP. NORM WALLIN	✓		
REP. SHEILA RICE, VICE-CHAIR	✓		
REP. BOB BACHINI, CHAIRMAN	✓		

March 15, 1991
SB 394

DRAFT NO. 4
March 14, 1991

PROPOSED AMENDMENTS TO SB 394 (THIRD READING COPY)

1. Page 4, line 15.
Following: "provided."
Insert: Utilization review does not include routine claim administration or determination which does not include determinations of medical necessity or appropriateness."

2. Page 4, lines 16 through 20.
Strike: Subsection 5 in its entirety

3. Page 6, line 17.
Strike: "BY A UTILIZATION REVIEW AGENT AS"
Insert: "made on appeal or reconsideration as provided in [section 6] adverse to a patient or to an affected health care provider may not be made on a question relating"

4. Page 6, lines 19 through 22.
Strike: lines 19 through 22 in their entirety
Insert: "of a health care service without prior written findings, evaluation and concurrence in the adverse determination by a health care professional trained in the relevant area of health care. Copies of the written evaluation, findings, and concurrence shall be provided to the patient on request in compliance with Title 33, Chapter 19."

5. Page 6, line 23 through page 7, line 6.
Strike: subsection 2 in its entirety
Renumber: subsequent subsection

6. Page 7, line 7.
Following: "determination"
Insert: "made on appeal or reconsideration as provided in [section 6]"

7. Page 7, line 9.
Strike: "physician"
Insert: "health care professional"

8. Page 7, line 11.
Strike: "physician or other"

9. Page 7, lines 11 and 12.
Strike: ", as the case may be,"

10. Page 8, line 6.
Strike: "has"
Insert: shall be provided at least

11. Page 8, line 10.
Strike: "30"
Insert: "60"

EXHIBIT 10
DATE 3/15/91
SB 394

EXHIBIT 11
DATE March 15, 1991
SB 394

In The Trenches By Gary A. Morse, M.A., M.S.

"Earth to HMOs...come in"

Provider Evaluator: "I just did an assessment on Tom Toxic. He's abusing seven street drugs and three pharmaceuticals, and drinks a quart of vodka a day. I recommend detox and inpatient until we see if he can be downloaded to day status. He'll need some psych also; has a history of major depression with several suicide attempts."

Insurance Adviser: "Okay. He's got HMO coverage with Less is Best of Persnickety, Ohio. I'll call 'em for admission clearance — I think they might still be in the office."

HMO Verifier: "Good afternoon, Less is Best! The end of your stay is just a day away!

Adviser: "I'm calling from Provider Anonymous, and we have Tom Toxic in our waiting room. He has Less is Best coverage and clearly has a dual diagnosis."

Verifier: "Sorry, our policies don't cover gunfighting; we don't cover swordfighting either, for that matter."

Adviser: "Not duel diagnosis, *dual* diagnosis — you know, co-existing psych and CD problems. What kind of training do you have?"

Verifier: "Oh, lots! I just learned how to use the FAX machine yesterday, and next week we learn how to mince words! So tell me about this gunfighter. Does he get drunk and shoot people or something?"

Adviser: " Is coverage available for Mr. Toxic, or not?"

Verifier: "You don't have to get so upset. After all, I'm a Certified Restrictor And Prognosticator, you know. I don't have any details on duel diagnosis for Toxic here, although I see that he does have preventive orthomolecular intracranial combustion coverage. Can I call you back on Monday?"

Adviser: "This man is severely ill, Madam; he has a fatal disease. He may not live until Monday!"

Verifier: "Well why don't you give him some Anti-Buse or something to hold him over. I hear that stuff tastes pretty good."

Adviser: "It's called Antabuse, and that would be highly inappropriate. Can I talk to your supervisor, please?"

Verifier: "I don't have a supervisor, so there! But I know one thing, we only cover detox after outpatient failure, and the insured must own a green Mustang with yellow pinstripes. If he meets those criteria and you have a 90 percent or better recovery rate that has been verified by Ralph Nader, then you get six days for rehab. But remember, not a day more! Oops! It's five after five, gotta go. Bye-bye!"

Adviser: "It's the same old story. This poor guy has been paying his share of premiums for two years. He thinks he's covered, but he really isn't, considering the shape he's in. What are we supposed to do? He can't go to the County program because, technically, he has insurance."

Evaluator: "This stuff is driving me nuts. I wonder what it costs to get into a Wendy's franchise these days . . ."

This exaggerated farce has been brought to you by the thousands of frustrated CD professionals who would simply ask managed care companies to 1) write clear and realistic CD treatment policies, and 2) hire staff that speak addictionese.

Gary A. Morse is director of chemical dependency programs at Penrose Hospital in Colorado Springs, CO.

EXHIBIT 12
DATE March 15, 1991
~~HB~~ SB 394

March 15, 1991
Testimony on SB 394
Before the House Business & Economic Development Committee

IN OPPOSITION TO SB 394
David Hartman
Montana Education Association

Utilization review procedures have proven effective in controlling unnecessary and inappropriate medical procedures and services.

Confronted with skyrocketing medical care costs and the inflationary health insurance premiums that go along with them, many employee groups in Montana, working cooperatively with their employers, have instituted utilization review, case management and other procedures to keep unnecessary or inappropriate medical services to a minimum.

SB 394, in its present form, would effectively eliminate most utilization review services currently available in Montana. The problem remains in subsections 2 and 3 of proposed Section 4. It also represents a contradiction.

While subsection 1 of Section 4 at page 6 was amended in the Senate to permit determinations as to the necessity or appropriateness of proposed medical procedures or services to be made by a utilization review agent (in most cases a registered nurse) in accordance with standards or guidelines approved by a physician, subsections 2 and 3 of this Section 4 at pages 6 and 7 still requires that determinations be made by physicians.

I urge your "do not pass" on SB 394. In the alternative, I urge the amendment of SB 394 to eliminate subsection 2 of proposed Section 4 at pages 6 and 7, and amend subsection 3 at page 7 by deleting the word "physician" at page 7, line 9, and replacing it with the word "agent."

Acting upon these proposed amendments will at least eliminate the contradictions now found in proposed Section 4.

The fact of the matter is, registered nurses, using guidelines and criteria approved by physicians, make determinations under utilization review programs on the need and appropriateness of proposed medical services. We can all appreciate how much utilization review services would cost if doctors made these decisions!

Blue Cross and Blue Shield of Montana representatives have backed off their opposition to SB 394 in its amended form. It's possible that the Blues can accommodate the direct participation of a "physician trained in the relevant area

of health care" in the utilization review process as contemplated by SB 394 in its present form.

It's possible that the Blues have figured out that, under SB 394 in its present form, they may be the only organization that could provide utilization review services in Montana, thus "cornering the market" on this popular cost control device.

Many reputable companies provide utilization review services on a nationwide basis. Most if not all of them use registered nurses as utilization review agents. None of them is going to change the way they do business for the small fraction of client potential in Montana. These national utilization review companies just won't do business in Montana.

Finally, it must be noted that the medical care providers who have supported SB 394 don't want anyone looking over their shoulders as they prescribe medical treatment, places of treatment, and services. After all, there's money to be made. The last people they want keeping an eye on them are utilization review agents who have the gall to conclude that an alternative $1,000 procedure for a specific medical condition is just as effective as the $10,000 procedure that the provider is proposing. The fact of the matter is the utilization review agents are usually right and they are saving patients, employees and employers a lot of money by keeping health care costs and health insurance premiums down.

I urge your "do not pass" on SB 394. In the alternative, I urge your action on the amendments in subsections 2 and 3 of proposed Section 4 which I identified earlier.

Thank you.

EXHIBIT 12A
DATE March 15, 1991
SB 394

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 15 day of March, 1991.

Name: DAVID HARTMAN

Address: 1232 E 6TH AVE
HELENA, MT 59601

Telephone Number: 442-4250

Representing whom?

MONTANA EDUCATION ASSOCIATION

Appearing on which proposal?

SB 394

Do you: Support? ____ Amend? ____ Oppose? X

Comments:

SEE PREPARED TESTIMONY

X AS TO THE PROPOSED AMENDMENTS: DELETE "HEALTH CARE PROFESSIONAL" IN AMENDMENTS 4-7, AND REPLACE WITH "UTILIZATION REVIEW AGENT."

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

Ex. 13
3/15/91
SB 394

Although the department does not object in principal to submitting utilization review plans to the commissioner of insurance, the department must point out that this requirement will require extensive administrative time and effort at a time when other essential administrative requirements are increasing and funding for additional staff is scarce or nonexistent.

We do not believe that the additional requirements of this bill are warranted with respect to the department's medical assistance programs. We ask that the committee carefully consider the impact of this bill in terms of resulting increases in the cost of performing utilization review and the administrative and effectiveness problems caused to the department's utilization review programs. We would ask that SB 394 be amended to specifically exclude the Montana medicaid and state medical programs. Attached for your review is a proposed amendment that would do just that.

If the committee does not wish to exclude these programs from this legislation, we would ask that the second set of attached amendments be adopted. These amendments would allow utilization review programs to use health care professionals other than physicians to perform medical necessity review. The amendments would also exempt the medicaid and state medical agencies from the appeals provisions provided in Section 6 since such programs already provide for reconsideration and appeal under reasonable timelines consistent with federal law.

Thank you for your consideration of this request.

Submitted by: Julia E. Robinson

Julia E. Robinson, Director
Department of SRS

med.legtests.394

DATE March 15, '91
HB SB 394
Exh #13

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

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(406) 444-5622
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TESTIMONY OF THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES BEFORE THE
HOUSE BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE
(RE: SB 394 Conduct of Utilization Review)
MARCH 15, 1991

Senator Svrcek has introduced Senate Bill 394 to regulate the conduct of utilization review (UR) by health insurers and other third party payers. SRS is concerned about this bill because of its effects upon the Department's utilization review activities for the medicaid and state medical programs. SRS is not opposed to the concept of utilization review standards. To the contrary, the Department, in consultation with appropriate health care professionals, already has developed standards to control its utilization review activities.

We believe the provisions of this bill are unnecessary with respect to the medicaid and state medical programs, and that these programs should be exempted from the provisions of this bill. At a minimum, we feel that the bill should be amended to address particular effects of this bill upon the Department's utilization review activities.

Utilization review is one of the most important avenues available to contain rapidly escalating health care costs while ensuring that persons receive medically necessary care in the most appropriate and least restrictive setting. Medicaid and the state medical program currently operate an extensive utilization review program. A variety of health care professionals and health care review organizations contract with the Department to conduct medical necessity determinations. These providers include physicians, dentists, speech therapists, audiologists, and other health care professionals. These contracts allow Medicaid to utilize the most appropriate specialist for the area of care being reviewed.

If in the course of this review a claim is denied as not being medically necessary, both the "patient" and the medical care provider are given an explanation of why the claim is being denied and afforded an opportunity for reconsideration by the reviewer.

If the patient or provider is not satisfied with the results of the reconsideration, they are entitled to a due process hearing to challenge the decision. The patient or provider may present

testimony from the health care professional of their choice to support the care provided or to dispute the review standards employed on behalf of the department. An objective hearing officer determines the outcome.

In addition, the Department distributes its utilization review criteria to providers and makes the criteria available to the public upon request.

This bill as proposed would add unnecessary duplication to this process in the following areas:

The bill title and Section 4 (2) and (3) would require that a physician conduct all medical necessity denials. We do not believe that a physician has the expertise in all areas to review medical care provided by other health care professionals. For example, physician review of the medical necessity of dental care would be as unacceptable to a dentist as dentist review of an appendectomy would be to a surgeon.

The physician review requirement in the bill would require that, in addition to contracting with appropriate health care professionals in the area of review, the department would be required to pay a physician to review the same information. This duplication of review, conservatively estimated, would cost an additional $30,375 per year in the medicaid program alone. This physician review would benefit neither the recipient nor the provider.

Medicaid has in the past had some difficulty finding physicians willing to perform medical necessity review, both because of the nature of the work and the amount of time it requires away from their practice. Section 3 (4) and section 6 (2) will contribute to this difficulty. These sections require the physician to be reasonably accessible to patients and health care providers <u>at all times</u> and to complete utilization reviews within 30 days of receipt of the records. Most of our medical reviewers are in private practice. To require that they be available at all times would seriously impact their private practices.

The requirement to complete review within 30 days of receipt of the record would not be a problem in the majority of cases. In some instances, however, these cases may contain records that are 6 to 36 inches thick. Again, a physician or other health care professional with an active private practice may not be able to complete a review within this time frame. An inability to contract with physicians because of these extra review requirements would threaten the department's ability to run any effective utilization review program. This would significantly increase the cost of the medicaid and state medical programs to the taxpayer.

Further, this legislation will increase the costs of administering the medicaid program. The bill provisions will create the need for at least an additional .5 FTE to manage the program, coordinate the 30-day requirement, and track all utilization review activities.

DATE March 15 1991
HB SB 394

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
(406) 444-5622
FAX (406) 444-1970

Amendment to Senate Bill 394
(RE: Utilization Reviews)
Third Reading Copy

1. Page 1, line 19.
   Following: "UTILIZATION REVIEW"
   Insert: "EXEMPTING UTILIZATION REVIEW ACTIVITIES PERFORMED ON BEHALF OF THE MONTANA MEDICAID AND STATE GENERAL RELIEF MEDICAL ASSISTANCE PROGRAMS;"

2. Page 5, lines 8 through 12.
   Following: "care"
   Strike: ", EXCEPT THAT A UTILIZATION REVIEW PLAN FOR HEALTH CARE SERVICES UNDER THE GENERAL RELIEF MEDICAL ASSISTANCE OR MEDICAID PROGRAMS PROVIDED FOR IN TITLE 53 NEED NOT REFLECT COMMUNITY STANDARDS OF CARE"

3. Page 10, line 11.
   Following: "agency"
   Insert: ", except that utilization review for health care services provided under the Montana medicaid and state general relief medical assistance programs provided for in Title 53 is exempt from the provisions of [this act]"

- end -

Rationale: The proposed amendments exempt from the provisions of the act persons or entities performing utilization reviews with respect to health care services provided under the Montana medicaid and state general relief medical assistance programs provided for in Title 53. The amendments would also delete references to such programs which the exemption renders unnecessary.

Submitted by: Julia E. Robinson

Julia E. Robinson, Director
Montana Department of Social and Rehabilitation Services

Ex. 13
3/15/91
SB 394

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

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Amendment to Senate Bill 394
(RE: Utilization Reviews)
Third Reading Copy

1. Page 1, line 15.
Following: "PATIENT"
Insert: ", OR IN THE CASE OF UTILIZATION REVIEWS PERFORMED ON BEHALF OF THE MONTANA MEDICAID AND STATE GENERAL RELIEF MEDICAL ASSISTANCE PROGRAMS, BY REQUIRING REVIEW IN ACCORDANCE WITH STANDARDS OR GUIDELINES APPROVED BY A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL TRAINED IN THE RELEVANT AREA OF HEALTH CARE;"

2. Page 6.
Following: line 11
Insert: "(1)"

3. Page 6, line 13.
Following: "state"
Insert: ", other than such a program employed by or on behalf of the Montana medicaid or state general relief medical assistance programs,"

4. Page 6, line 15.
Strike: "(1)"
Insert: "(a)"

5. Page 6, line 23.
Strike: "(2)"
Insert: "(b)"

6. Page 7.
Following: line 6
Insert: "(2) A program of utilization review with regard to health care services provided in this state and reimbursed by the Montana medicaid or state general relief medical assistance programs, must require that a determination as to the necessity or appropriateness of an admission, service or procedure must be made in accordance with standards or guidelines approved by a physician or other health care professional trained in the relevant area of health care."

EXHIBIT
DATE March 15, 199
SB SB 394

7. Page 7, line 9.
Following: "physician"
Insert: "or other health care professional"

8. Page 8.
Following: line 13
Insert: "(3) This section does not apply to health care services provided in this state and reimbursed by the Montana medicaid or state general relief medical assistance programs."

- End -

Rationale: The proposed amendments address special circumstances which apply only to utilization review programs designed to assure medical necessity and appropriateness of medical services paid for by the Montana medicaid and state general relief medical assistance programs. The amendments allow utilization reviews under these programs to continue to use appropriate health care professionals other than physicians to develop guidelines and standards for review purposes. The amendments exempt these government programs from the appeal provisions provided in Section 6, because such programs already provide for appeal under different timelines consistent with federal law.

Submitted by: Julia E. Robinson
Julia E. Robinson, Director
Montana Department of Social and Rehabilitation Services

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

SB 394

BUSINESS & ECONOMIC DEVELOPMENT COMMITTEE BILL NO. _____

DATE MARCH 15, 1991 SPONSOR(S) SEN. SVRCEK

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Tom Hopgood	Health Ins Assoc America		✓ Amend
DAVID HARTMAN	MEA		AMEND
DOLORES DEYERLE	ST. PETER'S HOSP.	✓	
[illegible]	RIMROCK FDN	✓	
Pat Melby	Rimrock Foundation	✓	
Dave Barnhill	Insurance dept	—	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		AMEND
Mary Moulton	Medicaid Division Dept SRS		amend
Steve Brown	Blue Cross-Blue Shield	X as amended	
Mary McCue	MMHCA	✓	✓ amend
Jim Ahrens	Mont Hospital Association	✓	
Terry Fosbender	CDPHP	✓	
Merle Jamison	Rocky Mtn. Patient Center	✓	
Ann Bellwood	RMTC	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

REP. SONNY HANSON said he knew what he was voting for when he voted against it. This proposal is tax money for the General Fund for redistribution and is not to establish taxes for inspection and operation of the systems. They are entirely different, and the fact that rates were raised on the others is comparable.

EXECUTIVE ACTION ON SB 394

Motion: REP. PAVLOVICH MOVED SB 394 BE CONCURRED IN. REP. PAVLOVICH moved to amend SB 394. **EXHIBIT 1.**

Discussion:

Pat Melby said these amendments were drafted after working with Blue Cross/Blue Shield, the Health Insurance Association of America, and other providers to make the bill acceptable to everyone. No one is real happy with it, so it must be a good compromise. The first amendment was requested by Mr. Hopgood of the HIAA to insure this bill did not cover routine claims administration. Amendments 2 through 9 were to make clear utilization review of health care services by an insurance company did not always have to be performed by a physician. The bill as it reads now would require a physician to review everything. This encourages the use of a health practitioner trained in the particular area. Numbers 10 and 11 have to do with the time frames for an appeal by a patient who has had an initial denial. Right now the patient has 30 days, this would give them at least 30 days. Number 11, extends the time for an insurance company to make a decision after medical records are received from 30 to 60 days.

REP. BACHINI has notations on Amendment #4 and #7 that Mr. Hartman opposes the amendments.

Dave Hartman, subsequent to the hearing on Friday, has been able to confer with legal representatives for private firms operating nationwide to provide utilization review services. They said they could comply with SB 394, as amended in the Draft #4, March 14 document, with the possible exceptions of the more exotic practices in Montana including naturopathic treatment and acupuncture. Mr. Hartman withdrew the objections raised on Friday on these proposed amendments and SB 394 as amended.

REP. PAVLOVICH stated item # 13 of **EXHIBIT 1** was proposed by the Montana Dental Association with the concurrence Pat Melby.

Discussion:

Roger Tippy stated the proponents did not intend the bill to cover the peer review. If someone has a problem with the procedure of a dentist and a complaint is filed, mediation procedure is the first step. Common sense judgments are applied, involving all parties. Blue Cross/Blue Shield or other third

parties can ask the dental association to set up mediators for a peer review. Wording in the early part of the bill was very broad and proponents agreed to an amendment remove that as it creates a formal structure rather than mediation in a hometown.

Pat Melby said Mr. Tippy is correct, this bill was not intended to include the process of peer review, which is different than the peer review of utilization review. Dentists are not exempt from utilization review, only the peer review which is a different process.

Vote: Motion to amend carried unanimously.

Motion: REP. PAVLOVICH MADE A SUBSTITUTION MOTION SB 394 AS AMENDED BE CONCURRED IN.

Discussion:

REP. CROMLEY has concern if a patient himself wishes to review the medical services being provided, he may be prevented from doing so.

Pat Melby said this bill applies to the review of a health care service provided by a health care provider by an insurance company who has the contract to pay for the health care service if the service is medically necessary. The process involves sending initial health care service records to the utilization reviewer, usually a contractor of the insurance company, to make a determination whether the service is necessary, and tell the patient if the insurance will not pay for it. Page 4, lines 9 through 15, says the review will be utilized directly or indirectly in order to determine whether the health care services will be paid, covered or provided. It does not cover the instance where a patient has gone for a second opinion.

REP. TUNBY said apparently there is no one here from SRS concerned about the two amendments.

REP. BACHINI said the amendments SRS submitted have not been addressed.

Pat Melby indicated there were two sets of amendments. The first would exempt medicaid from utilization review. The second was proposed in the event medicaid was not exempt, to clarify the same things clarified in the proposed amendments. Mr. Melby met with Nancy Ellery at SRS on the amendments. Ms. Ellery said SRS would like to be excluded from the bill, but they could live with it with amendments.

REP. BENEDICT said previously when someone is not here to propose or support their amendments, the committee let the amendments go by the wayside. If it had been important to SRS, they would have been here.

Vote: Motion that SB 394 as amended be concurred in carried unanimously.

ADJOURNMENT

Adjournment: 10:20 A.M.

Rep Bob Bachini
BOB BACHINI, Chair

Jo Lahti
JO LAHTI, Secretary

BB/jl

HOUSE OF REPRESENTATIVES

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

ROLL CALL DATE March 20, 1991

NAME	PRESENT	ABSENT	EXCUSED
REP. JOE BARNETT	✓		
REP. STEVE BENEDICT	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. ALVIN ELLIS, JR.	✓		
REP. STELLA JEAN HANSEN	✓		
REP. H.S."SONNY" HANSON	✓		
REP. TOM KILPATRICK	✓		
REP. DICK KNOX	✓		
REP. DON LARSON			
REP. SCOTT MCCULLOCH	✓		
REP. BOB PAVLOVICH	✓		
REP. JOHN SCOTT	✓		
REP. DON STEPPLER			
REP. ROLPH TUNBY	✓		
REP. NORM WALLIN			
REP. SHEILA RICE, VICE-CHAIR	✓		
REP. BOB BACHINI, CHAIRMAN	✓		

1:00 PM
3-21-91
VMO

HOUSE STANDING COMMITTEE REPORT

March 21, 1991

Mr. Speaker: We, the committee on Business and Economic Development report that Senate Bill 394 (third reading copy -- blue) be concurred in as amended .

Signed: Bob Bachini
Bob Bachini, Chairman

And, that such amendments read:

1. Title, line 12.
Strike: "PHYSICIAN"
Insert: "HEALTH CARE PROFESSIONAL"

2. Page 4, line 15.
Following: "provided."
Insert: "Utilization review does not include routine claim administration or determination that does not include determinations of medical necessity or appropriateness."

3. Page 4, lines 16 through 20.
Strike: subsection (5) in its entirety

4. Page 6, line 17.
Strike: "BY A UTILIZATION REVIEW AGENT AS"
Insert: "that is made on appeal or reconsideration as provided in [section 6] and that is adverse to a patient or to an affected health care provider may not be made on a question relating"

5. Page 6, lines 20 through 22.
Strike: lines 20 through 22 in their entirety
Insert: "a health care service without prior written findings, evaluation, and concurrence in the adverse determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence must be provided to the patient on request as provided in Title 33, chapter 19."

6. Page 6, line 23 through page 7, line 6.
Strike: subsection (2) in its entirety
Renumber: subsequent subsection

7. Page 7, line 7.
Following: "determination"
Insert: "made on appeal or reconsideration, as provided in [section 6],"

8. Page 7, line 9.
Strike: "physician"
Insert: "health care professional"

9. Page 7, line 11.
Strike: "physician or other"

10. Page 7, lines 11 and 12.
Strike: ", as the case may be,"

11. Page 8, line 6.
Following: "has"
Insert: "at least"

12. Page 8, line 10.
Insert: "30"
Insert: "60"

13. Page 10, line 19.
Following: line 18
Insert: "(3) A peer review procedure conducted by a professional society or association of providers is exempt from the provisions of [sections 1 through 9]."

EXHIBIT 1
3/20/91
HB 394

Amendments to Senate Bill No. 394
Third Reading Copy

For the House Committee on Business and Economic Development

Prepared by Paul Verdon

March 20, 1991

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Ex. 1
3/20/91
HB 394

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